# MILL NECK MANOR SCHOOL FOR THE DEAF

## Parent/Guardian Annual Medical Information *(Please Print)*

Student's Name: _____ Date of Birth: ____/____/____
*month day year*

Name of Primary Physician : _____ Telephone Number: (___)_____

Physician's Address: _____
*(Street Address) (City, State) (Zip)*

- Has your child had any serious illness, injury, seizures or surgery in the past 12 months?
☐ Yes ☐ No If yes, please describe: _____

- Does your child have any physical activity limitations or restrictions?
☐ Yes ☐ No If yes, please describe: _____

- Does your child use any supportive devices (i.e. body brace, crutches)?
☐ Yes ☐ No If yes, please describe: _____

- Does your child have allergies?
☐ Yes ☐ No If yes, please describe symptoms, source of allergy, dietary restrictions, etc:

- Does your child require medication on a regular basis?
☐ Yes ☐ No If yes, please give name(s) of medication, dosage and why it is needed:

- Does your child require ear plugs for swimming?
☐ Yes ☐ No If yes, a physician's note is required; ear plugs will be provided by parent/guardian.

- Does your child have visual problems?
☐ Yes ☐ No If yes, please describe: _____

☐ Wears glasses ☐ Wears contact lenses
Corrective lenses are needed for: ☐ close work ☐ distance ☐ at all times*
(*Only POLYCARBONATE LENSES are acceptable for physical education.)

- Please check one:
  - ☐ My child has been examined by our private physician in the past 12 months (report attached).
  - ☐ My child has an appointment for a physical examination on ____/____/____.
*month day year*

- Does your child wear orthodontic braces?
☐ Yes ☐ No If yes, please describe: _____

- Please check one:
  - ☐ My child has had a dental examination within the past 12 months (report attached).
  - ☐ My child has an appointment for a dental examination on ____/____/____.
*month day year*

Dentist/Orthodontist's name: _____ Tel. Number: (___)_____

CONSENT FOR TREATMENT: I hereby give permission for my child, _____, to be taken to the Emergency Room at North Shore University Hospital in Glen Cove for observation or treatment in the event of illness or accident. I also give my permission for any emergency surgical procedures that may be considered necessary by hospital authorities in the event that I cannot be contacted.

Parent/Guardian's Name (Please Print): _____

Signature of Parent/Guardian: _____ Date: _____